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Suelle Micallef Marmara
University of Wisconsin - River Falls, suelle.micallefmarmara@uwrf.edu

Gülşah Kemer
Old Dominion University, gulsahkemer@gmail.com

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RESEARCH ARTICLE

An investigation of healthcare professionals' perspectives on the tasks of mental health counselors in hospital settings

Suelle Micallef Marmara' | **Gülşah Kemer**

Department of Counseling and Human Services, Old Dominion University, Norfolk, Virginia, USA

Correspondence
Suelle Micallef Marmara', Department of Counseling and School Psychology, University of Wisconsin River Falls, 375 Wild Rose Avenue, River Falls, WI 54022, USA.
Email: suelle.micallefmarmara@uwrf.edu

Present address
Suelle Micallef Marmara, Department of Counseling and School Psychology, University of Wisconsin River Falls, River Falls, WI 54022, USA.

Abstract

In this study, we attempted to understand what other healthcare professionals considered mental health counselors' (MHCs) tasks in their hospital setting to facilitate medical and mental health services and enhance patients' well-being. Using an exploratory sequential mixed-methods design (concept mapping), we obtained 3 regions of MHCs' tasks (i.e., Overarching Roles and Responsibilities of MHCs in the Hospital Setting, MHCs' Specific Roles in the Hospital Setting, and MHCs' Roles and Responsibilities as a Multidisciplinary Team Member) represented in 11 clusters. We discussed the results with implications for MHCs, healthcare professionals, counselor educators, and researchers, along with the current study's limitations.

KEYWORDS

concept mapping, healthcare professionals' perspectives, hospital settings, MHCs' tasks

INTRODUCTION

An increasing number of researchers are highlighting the connection between mental and physical health, noting a gradual development of mental health issues with the progress or deterioration of patients' medical issues (Grover et al., 2020; National Center for Health Statistics, 2018). Counseling in hospital settings is a newer area for counselors' practice, requiring different focus areas and counseling interventions. For example, mental health counselors (MHCs) in hospital settings must focus on the patient's medical condition, their understanding of it, and its implication on their physical, mental, and social health and other life-concerning issues. However, to date, scholars have minimally discussed the distinct tasks and responsibilities of MHCs in hospital settings to enhance patients' well-being (Johnson et al., 2021; Li et al., 2022).

In 20/20: A Vision for the Future of Counseling, 31 different counseling organizations agreed upon a unified definition for counseling: Professional counselors are trained to build therapeutic relationships that support and empower persons, groups, and families to reach personal goals of mental well-being, wellness, education, and career (Kaplan et al., 2014). Although this definition places all counselors with different specialty areas under one umbrella, there is a gap in the literature to identify and clarify the specific tasks of MHCs in hospital settings. As part of medical care for patients, counseling in hospital settings must be coordinated with other professional services, requiring MHCs to practice as professional team members. All team members in hospital settings come from different professional backgrounds and technical specialties (e.g., doctors, nurses, and social workers), holding different perspectives and expectations about team functioning and other members' roles (Garman et al., 2006; Schot et al., 2020). These diverse role definitions and expectations influence how MHCs are perceived and are invited to work with other healthcare professionals on the team. For example, some professionals may view patient care as holistic care incorporating physical and mental health needs (Haar et al., 2020). Thus, a patient with a chronic diagnosis, such as cancer, could benefit from counseling to process cancer-related information that triggers anxiety and its impact on their mental well-being earlier than they present with psychological challenges (Haar et al., 2020; Hall & Hall, 2013; Weinert & Meller, 2007). However, other healthcare professionals may view patients' health and wellness differently than counselors (Johnson & Mahan, 2019). Li et al. (2022) identified misconceptions about the counseling

profession and different views of mental and physical health among professionals within the multidisciplinary team, hindering the interdisciplinary communication and collaboration between medical and mental health professionals. MHCs report experiencing confusion and tension about interprofessional collaboration and consultation (Johnson et al., 2021; Li et al., 2022), as professional diversity in interprofessional collaboration may create ambiguity and contradicting expectations (Li et al., 2022; Mitchel & Boyle, 2015). Consequently, counseling in hospital settings enacts complex and often vaguely defined roles, warranting further research describing the different tasks of MHCs in these settings.

Professional counselor identity in hospital settings

The professional counselor identity has been at the forefront for counselor educators and practitioners as the field has evolved over the last several decades. Among multiple subspecialties of the counseling field, the two most prominent ones are school counseling and mental health counseling (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2023). Although several counseling publications have addressed the professional counselor identity of focused areas, they primarily focused on school counselor trainees' professional identity development (Grimes, 2020; Moss et al., 2014), MHCs' attitudes toward professional identity (Klein & Beeson, 2022), and counselor educators' identity development (Calley & Hawley, 2008).

The role and focus of the MHCs in hospital settings differ slightly from counselors' roles in other areas (e.g., schools and colleges). Li et al. (2022) highlighted the need for MHCs in integrated behavioral health settings to be equipped with additional medical knowledge. Specifically, in addition to clients' intrapersonal and social presentations, MHCs must also know about patients' medical history as well as the impact of the medical environment on their overall well-being. This means taking certain factors into account, such as medical complications, clients' internal experiences (e.g., emotional, spiritual, and physical) with those, potential life changes resulting from the illness and/or medical procedure, and even difficulty accessing preventive care from medical professionals (Hall & Hall, 2013; Li et al., 2022). Additionally, Pestoff et al. (2016) described MHCs as the "spider-in-the-web" (p350), acting as case managers to offer continuous support, build a relationship with patients, and provide holistic, ethical, and psychological perspectives to the patients while being more available and accessible than the medical professions. For example, as patients went through genetics-related medical problems, they described the essential tasks of MHCs as providing genetic risk assessment based on clinical screening, prophylactic treatment, and discussing reproductive options. Moreover, Moeller (1992) suggested that, together with addressing patients' emotional needs, MHCs could also address staff needs and stressors. They specifically highlighted the positive impact of enrolling a counselor in strengthening nurses' coping skills, increasing awareness and practice in self-care, and improving the overall effectiveness of nursing care in the hospital setting. In the Johnson et al. (2021) study, MHCs reported utilizing common counseling factors, such as unconditional positive regard, empathy, and reflective listening, to support the functionality of the interprofessional team. Moeller (1992) described the roles of MHCs as providing education and individual and group counseling to nurses, focusing on interpersonal communication skills, team building, conflict and stress management, and self-care. Thus, MHCs' tasks do not only serve patients but also serve colleagues from other healthcare professions in hospital settings.

The critical role of MHCs in hospital settings

Counseling in medical settings complements patient care to be catered to the whole person. Zhang et al. (2016) found a significant positive correlation between disease severity and illness perceptions with maladaptive coping, stress, anxiety, depression, and quality of life. Stress management, adaptation to illness, and smoking cessation have long been viewed as critical psychological interventions to be addressed in the care of medical patients, resulting in reduced sickness due to chronic illness (Peyrot & Rubin, 2007). With the absence of counselors in hospital settings, patients' psychological and mental implications of their disease risk are limited and treated only through the medical model. Thus, counseling in hospital settings provides the opportunity to see and treat patients as a whole and not as part of the whole.

Ramnarain et al. (2021) further detailed the need to address patients' mental health needs and well-being in hospitals by highlighting the implications of medical procedures, illnesses, and overall intensive care stays as traumatic experiences that can have lasting effects. Hall and Hall (2013) reported that patients impacted by medical trauma developed significant clinical reactions, such as anxiety, depression, post-traumatic stress disorder (PTSD), complicated grief, and somatic complaints. Early screening of the psychological impact of acute critical illness such as anxiety and depression to acute stress disorder (ASD) and PTSD could be significant in preventing long-term psychological impairment (Ramnarain et al., 2021). Counselors could support medical trauma prevention and assessment by providing emotional and psychological support to patients in medical settings (Hall & Hall, 2013; Johnson & Mahan, 2019). Various research studies specify the importance of psychological care when patients show signs of PTSD or ASD (Bisson et al., 2021; Ramnarain et al., 2021). However, no researchers have yet studied the effectiveness of integrating onsite counseling services in hospital settings so that other healthcare professionals in the hospital setting can acknowledge the value of their services. On the other hand, a growing body of research demonstrated the effectiveness of integrating behavioral and mental health care within the primary care setting in

improving health outcomes (e.g., McGough et al., 2016; Pomerantz et al., 2009).

Since the COVID-19 pandemic, there has been a dramatic increase in individuals reporting mental distress and mental illness, harvesting national attention by sharpening societal acknowledgment of the relationship between psychological and physical health (Javed et al., 2020; McGahey & Wallace, 2021). The State of Mental Health in America (2023) reported an increase from 11% to about 40% of adults reporting symptoms of anxiety and depression from 2019 to 2020 (Reinert et al., 2022). The latest data gathered through 2020 indicate that 21% of adults are experiencing a mental illness, equivalent to over 50 million Americans, with over half (54.7%) of these adults receiving no treatment (Reinert et al., 2022). With 54.7% of adults and 57.3% of youth suffering from mental illness not receiving treatment (Reinert et al., 2022), there is an increased need to provide individuals with easy access to mental health services. Therefore, McGahey and Wallace (2021) identified the omnibus approach to provide a one-stop shop that increases patients' accessibility to mental health care. They highlighted that many mental illnesses initially manifest as physical symptoms that the healthcare provider can treat by referring them to an in-house mental health evaluation—if in-house counseling is available. The in-house referral was reported to reduce long delays in accessing services, as outdoor mental health professionals may have longer waiting lists or not accept new patients.

Early intervention can significantly impact patients' post-discharge mental health (Grover et al., 2020) and support other professionals' services, such as doctors and nurses, who can contact the MHCs' service to explore patients' emotional needs (Schafer et al., 2009). MHCs in hospital settings can assist in merging psychological and physical health services in hospital settings to create a comprehensive continuity of care and ease access to mental health treatment. The lack of research on MHCs' roles and responsibilities in hospital settings highlights the limited information all stakeholders (e.g., MHCs, clinical supervisors, counselor educators, and other healthcare professionals) need to effectively integrate counseling services in these settings. Thus, in the current study, we sought to understand healthcare professionals' perspectives on the different tasks and responsibilities of MHCs to address the needs of patients in the hospital and facilitate the continuity of services in the hospital. Such knowledge offers further guidelines to MHCs and other healthcare professionals within the multidisciplinary teams, which can lead to increased counseling referrals and better use of their services. The directing research question of the current study was: According to healthcare professionals, what do MHCs do in the hospital setting to facilitate medical and mental health services and enhance patients' well-being?

METHODS

We utilized an exploratory sequential mixed-methods design (Hanson et al., 2005), concept mapping (CM) with a social constructivist framework (Kane & Trochim, 2007). Based on the assumption that each individual holds a unique set of ideas, CM research aims to portray different constructions or operationalizations of multiple realities (Goodyear et al., 2005) and organizes and mirrors diverse groups of people's ideas and perceptions to create insight, understanding, and agreement (Kane & Trochim, 2007; Rosa & Kane, 2012). As an exploratory sequential mixed-methods design, the data obtained in the initial qualitative phase of the study (i.e., generating statements/ideas) are further structured in a subsequent quantitative phase of inquiry (i.e., generating visual maps) and finalized in a focus group, all by the participants (Almeida, 2018; Hanson et al., 2005; Kane & Trochim, 2007).

CM effectively addresses different research questions in various fields, including counseling (e.g., Kemer, 2020) and social sciences (Hanson et al., 2005). In the counseling field, researchers examined beginning and expert counseling supervisors' cognitions and cognitive structures of their supervision sessions (e.g., Kemer, 2020; Kemer et al., 2014), what counselor trainees perceived as their responsibilities to contribute to their clinical supervision experiences (Rocha & Kemer, 2022), and clients' perspectives on early counseling alliance formation factors (Bedi, 2006).

Thus, CM was an ideal fit to address the research questions of the current study. It allowed us to (1) work with a small sample size to capture different professionals' voices, views, and beliefs about counseling within a multidisciplinary team in a hospital setting, (2) organize their opinions into different clusters, and (3) involve them in a focus group to interpret and finalize the results. As a result, CM procedures facilitated participants to be involved in different data collection and analysis and framework development phases. Kane and Trochim (2007) presented CM in six steps: (1) preparing for CM, (2) generating ideas, (3) structuring the generated ideas, (4) CM analysis, (5) interpreting the maps, and (6) utilization of maps. The sixth step focuses on developing an instrument from the first five steps. The scope of this study was to elicit knowledge on the role of MHCs in a hospital setting; thus, the sixth step was beyond the scope of the current research.

Step 1: Preparing for concept mapping

Participants

First, it was essential to define MHCs and healthcare professionals for the current study. MHCs hold a degree in clinical mental health counseling, which trains them to offer clinical services to those struggling with life problems, psychological and emotional issues, and mental health disorders (Neukrug, 2017). MHCs' practice focuses on the common ground of supporting individuals through a therapeutic relationship to reach well-being. In this study, MHCs refer to those working within hospital settings, specifically trained in both core areas of counseling and the specialty area of mental health counseling that include but are not limited to

psychological assessments, tests, techniques, and interventions for prevention and treatment of a range of mental health issues to support patients in reaching emotional and psychological well-being (CACREP, 2023). On the other hand, healthcare professionals comprise professionals from different health professional backgrounds, having different but complementary skills that work toward a common objective (Law Insider Dictionary, n.d.). Healthcare professionals study, prevent, diagnose, and treat human illness and injury as well as other mental and physical impairments according to individual needs (World Health Organization [WHO], 2013). For this study, healthcare professionals refer to the professionals employed as physicians, nurses, crisis clinicians, social workers, dietitians, physical therapists, and case managers, sharing the common goal of patients' cures and well-being.

We selected participants from different professionals functioning in multidisciplinary teams within a specific hospital setting in the Southeastern United States. We chose only one hospital setting for this study to control the potential effects of systemic and practice variations across hospitals (e.g., patients' services, a flowchart of roles and responsibilities, hospital ethos and culture, and team dynamics). The chosen hospital was also a good fit for the current study for two main reasons: (1) The hospital already had a counselor training clinic providing counseling services by 14 master's, 5 doctoral-level counseling interns, and 2 qualified MHCs with doctoral degrees serving both inpatient and outpatient units, and (2) the healthcare professionals were already exposed to counseling services within this hospital setting. Approximately 500 healthcare professionals worked at this hospital throughout the study procedures. A licensed professional counselor ran the counselor training clinic with considerable expertise in offering counseling services and training counselors in integrated behavioral healthcare (IBH) settings. MHCs and MHC trainees are the only professionals offering counseling services in this clinic. Thus, the healthcare professionals at this hospital could provide information on different tasks of the MHCs based on their professional experiences rather than perceptions without the experience.

Ensuring participants had the necessary working experience to speak of their perspectives on MHCs' tasks in the hospital setting was also critical. Therefore, eligible participants' criteria were determined as follows: (1) being at least 18 years of age; and (2) practicing as a doctor, nurse, social worker, case manager, chaplain, crisis clinician, dietitian, or physical therapist with a minimum of 6 months of experience working with MHCs (e.g., residency counselors) or master's/doctoral MHC trainees providing counseling services at the hospital. We identified 6 months as an adequate period for exposure to counseling services in a hospital setting to explain the phenomenon of specific tasks of MHCs in the multidisciplinary team. After receiving Institutional Review Board (IRB) approval, using purposeful sampling, we invited the stakeholders at the hospital to participate in the study via verbal approach/invitation and email.

In the current study, 27 participants showed interest in participating in the study, and 26 participants met the inclusion criteria. Twenty-six participants participated in at least one of the three data collection steps; a total of 10 participated in 2 (38.46%), and 5 participated in all 3 rounds of data collection (19.23%). Participant retention is a challenge in CM studies due to extensive involvement in the three steps of data collection; thus, researchers anticipated a smaller sample of participants to participate in the three rounds of data collection (Kane & Trochim, 2007). Thus, to support retention, we incentivized participants' involvement in three rounds of data collection. Each participant received a bag of candies for their participation in the generation of statements step and a $15 Amazon gift card for participating in the structuring of statements and focus group steps.

Out of 26 participants, 18 identified as female (69.23%) and 8 as male (30.77%), whereas 19 identified as White (non-Hispanic; 73.08%), 4 identified as African American/Black (15.38%), and 3 as Asian/Pacific Islander (11.54%). Seventeen participants claimed to have a European American background (65.38%), four identified with an African American ethnic background (15.38%), three with an Asian Pacific Islander ethnic background (11.54%), one participant disclosed to be an immigrant coming from Europe (3.85%), and one participant did not specify their ethnic background and reported as "other" (3.85%).

Per their professional roles, out of 26, 4 participants were doctors (15%), 6 were nurses (23%), 1 was a nurse practitioner (4%), 1 was a lactation consultant (qualified as a midwife; 4%), 2 were chaplains (7%), 1 was a dietitian (4%), 3 were crisis clinicians (12%), 2 were physiotherapists (8%), 4 were case managers (15%), and 2 were social workers (8%). All participants had direct working experience with MHCs and MHC trainees at the hospital. Seven participants stated that they had been working at the current hospital for the last 6 months to 1 year (27%), eight reported 1–3 years (31%), six reported between 3 and 6 years (23%), and six indicated working at the current hospital for more than 6 years (23%). Seven participants reported practicing their current profession for 6 months to 3 years (26.92%), 3 reported 3–6 years (11.54%), and 16 reported more than 6 years (61.54%). Fourteen participants stated having worked with counselors or counselor trainees before they started working at the current hospital (54%), whereas 12 did not have work experience with counselors or counselor trainees before their employment in the current hospital (46%).

Step 2: Generation of statements

Of 26 eligible participants who showed interest in the study, 25 participated in the first data collection round, resulting in a 96.15% response rate. Twenty-five healthcare professionals generated the conceptual domain for the phenomena under study (Kane & Trochim, 2007), MHCs' tasks in hospitals to enhance patients' well-being and facilitate other medical services. Volunteering participants accessed a Qualtrics

survey including the consent form, a short demographic survey, and guidelines on the generation of statements task and a prompt (e.g., one specific task of an MHC in this hospital to enhance patients' well-being and facilitate other medical services is_____). Twenty-five participants initially generated 119 statements describing MHCs' tasks in the hospital setting. We reviewed the statements for editing and synthesis purposes by removing redundant statements, splitting compound ideas, and creating consistency across statement presentations. During this process, it was essential to preserve the statements' overall integrity with their conceptual richness, nuances, and value of the data generated by the participants (Kane & Trochim, 2007). Obtaining 104 final statements representing 1 idea in each account, for the next step, we pilot-tested the next step's procedures with 2 nurses working at another hospital. We ensured that each statement was clear and understandable. We asked these external auditors if each statement represented only one idea, whereas the directions for the sorting task were easy to follow and on point. To ensure credibility and objectivity, the two nurses had extensive experience with integrated behavioral healthcare yet did not have any connections with the hospital from which the healthcare professionals participated in the current study. Both nurses suggested that all the instructions and documents for data collection in this step were clear and easy to follow.

Step 3: Structuring of statements

This step involved a sorting task to understand better the interrelationships among statements that lead to the conceptual domain structure (Kane & Trochim, 2007). Out of 25 participants in Step 2, 9 participated in Step 3. We also had a new participant in this step who met the inclusionary criteria and could not participate in Step 2 of data collection for personal reasons but was willing to participate in Step 3. Utilizing Proven by User (Proven by User LLC, 2023), we offered guidelines to 10 participants on the sorting task for 104 statements. Specifically, we asked participants to classify all the provided statements into different groups based on their understanding of the statements' interrelations and similarities and to name each category with a title representing their content.

Step 4: Concept mapping analysis

Once participants completed the sorting task, we used the statistical program R Editor (2019) to conduct multivariate statistical procedures that included creating a group similarity matrix (GSM) and running a multidimensional scaling (MDS) and a hierarchical cluster analysis (HCA; Kane & Trochim, 2007). Representing a square matrix displaying the number of participants who similarly grouped pairs of statements during the sorting task (Kane & Trochim, 2007), GSM was the data we used to run a two-dimensional, nonmetric MDS. MDS generated a point map showing each statement's location on the map and yielding a stress value, a central diagnostic statistic showing data fit for the MDS's two-dimensional solution. The range of stress values for most CM studies falls between 0.205 and 0.365 (Kane & Trochim, 2007), so the stress value of 0.212 in the current study indicated a good fit of the data to the two-dimensional map.

Then, we used the coordinate values of the two-dimensional solution obtained from MDS to run an HCA. HCA yielded a cluster tree, a visual representation of the statement clusters based on their conceptual similarities. Finally, we simultaneously worked on the point map and dendrogram to observe similar groups of statements with conceptual similarities. We obtained preliminary clusters with labels (using participants' labels as a guide) and a preliminary cluster map. Finally, as Kane and Trochim (2007) recommended, we sent the 10 preliminary clusters and 1 by-itself cluster to an external auditor. The auditor was an assistant professor of counseling with IBH clinical and research and mixed-methods methodology experiences, including CM. They offered two comprehensive comments on two statements and suggested a new cluster. After reviewing the auditor's feedback, we moved two statements to another cluster for a better conceptual fit, changed one cluster label, and formed a new cluster with a new title. These revisions led to preliminary clusters and regions to be reviewed during the interpretation session, that is, the focus group.

Step 5: Interpreting the maps—focus group

Five of the 26 participants agreed to attend the synchronized online focus group. According to Kane and Trochim (2007), having a smaller group of participants attending the focus group is expected. During the focus group, we asked the participants to observe how statements and their respective clusters seem conceptually fitting (Kane & Trochim, 2007). Being actively engaged in the session, participants discussed revision suggestions (e.g., moving statements across clusters and revising the label of the clusters) and engaged in consensus-seeking on the material presented. Reaching the goal of fully capturing participants' perspectives and controlling for researchers' bias via focus group (Bedi, 2006), the final clusters included 3 regions represented by 11 clusters.

Researcher's reflexivity and testimonial validity

The extent and quality of the relationship between the researcher and the research can threaten a study's trustworthiness (Hays & Singh, 2023). The first author is a former nurse and was a doctoral counseling intern at the chosen hospital. The second author is an associate professor of counseling and supervised many doctoral and master's students interned in the focused hospital, in addition to working with clients at a primary care location of the hospital. Considering our immersion in the topic and the research site under

study in varying degrees, we kept a reflexive journal throughout the data collection and analysis processes to reflect on potential biases, bracket all prior and current knowledge, and increase neutrality (Hays & Singh, 2023; Stahl & King, 2020). We noted how the research process, as well as the participants, data collection, and analyses, professionally and personally affected them, in addition to any hunches they had about potential results and descriptions of modifications to data collection methods, sources, and analyses. In addition, we had regular meetings to discuss the data collection and analyses throughout the study and reflected on the processes and their positionality. As part of the audit trail, these procedures were helpful reminders of how and why we made certain decisions and communicated with various stakeholders and critical informants (Hays & Singh, 2023; Stahl & King, 2020). Finally, testimonial validity is built into CM as participants generate, structure, and finalize the results, whereas researchers are only facilitators of this process (Bedi, 2006). To further keep our potential influence in check after each time we worked with data, we consulted with an external auditor to review and offer feedback on the objectivity of data analyses, increasing the validity of results and the trustworthiness of the procedures (Kane & Trochim, 2007).

RESULTS

Addressing the research question, participants generated 104 statements that described MHCs' tasks in the current hospital setting to facilitate medical and mental health services and enhance patients' well-being. Table 1 presents statements associated with the clusters and regions.

The first region, *Overarching Roles and Responsibilities of MHCs in the Hospital Setting*, was located on the bottom left quadrant of the map. It consisted of 2 clusters describing 29 MHCs' tasks to enhance patients' well-being. This region represented healthcare professionals' perspectives on MHCs' fundamental roles and responsibilities across the hospital setting and other specific roles and responsibilities counselors can engage in within specific hospital units. "Fundamental Roles and Responsibilities in the Hospital Setting" (cluster 1) described how MHCs provided emotional and psychological support to the patients. "Specific Roles and Responsibilities in Different Hospital Units" (cluster 2) presented tasks where MHCs addressed the unique needs of patients from different units.

The second region, *MHCs' Specific Roles in the Hospital Setting*, is spread across the upper to the bottom left quadrant of the cluster map. This region consisted of 4 clusters describing 38 MHCs' tasks representing the unique characteristics and skills MHCs need to provide effective counseling services. "Building Relationships with Patients" (cluster 3) included tasks with fostering a therapeutic relationship that promotes a safe patient environment. "Assessing/Evaluating Patients' Mental Health Status" (cluster 4) described the role of MHCs in identifying patients' present and future psychological care, treatment, and interventions needed both in the hospital and post-discharge. "Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to their Medical Condition" (cluster 5) highlighted MHCs' tasks to support patients facing the challenges of a new illness/diagnosis, treatment, loss, hospitalization, and future adjustments. Lastly, "Educating Patients" (cluster 6) in this region represented the MHCs' role of educator for the patients regarding their illness and mental health wellness.

The third region, *MHCs' Roles and Responsibilities as a Multidisciplinary Team Member* was situated in the map's upper and lower right quadrants. This area comprised 5 clusters describing 36 tasks MHCs implemented as multidisciplinary team members. In this region, MHCs were identified for "Advocating for Patients in the Multidisciplinary Team" (cluster 7), "Mediating Communication Between Healthcare Professionals, Patients, and Families" (cluster 8), and "Collaborating with Other Multidisciplinary Team Members on Patients' Care" (cluster 9). Additionally, through "Training Other Multidisciplinary Members on General Wellness and Mental Health" (cluster 10) and "Offering Training and Emotional Support to Other Multidisciplinary Team Members" (cluster 11), MHCs' role as educators for the healthcare professionals was also presented.

The three regions entailing the different tasks of MHCs in the hospital settings are also displayed on two conceptually meaningful dimensions (see Figure 1). Dimension 1, *Patient-Centered—Collaborative*, represented a continuum of areas highlighting MHCs' patient-centered tasks (left) and collaboration with other healthcare professionals (right). On the other hand, running from the bottom of the map to the top, areas of clusters in Dimension 2, *Assessment—Advocacy*, presented MHCs' tasks from patient assessment to advocacy.

DISCUSSION

CM results yielded various healthcare professionals' perspectives on MHCs' tasks in a hospital setting. The three regions and respective clusters offered a framework for MHCs and healthcare professionals to facilitate services and enhance patients' overall well-being while informing counselors and counselor education faculty and scholars on how to prepare counselor trainees further to practice in the hospital settings.

Across the three, unsurprisingly, the first and second regions (i.e., *Overarching Roles and Responsibilities of MHCs in the Hospital Setting* and *MHCs' Specific Roles in the Hospital Setting*) highlighted the need for MHCs to support patients emotionally by providing onsite counseling services. The emphasized provision of onsite counseling aligned with McGahey and Wallace's (2021) reports on the importance of delivering on-the-spot counseling and offering patients one-stop shopping in medical settings instead of sending them to outside services.

As part of the *Overarching Roles and Responsibilities of MHCs in the Hospital Setting* region, the respective statements from the first region instilled the understanding that healthcare professionals identified the need to integrate

TABLE 1 Region list with clusters and descriptions.

Region	Clusters	Few of the participants statements
Overarching roles and responsibilities of MHCs in the hospital setting	1. Fundamental roles and responsibilities in the hospital setting	St. 68 Recommend patients for therapeutic interventions St. 50 Provide an avenue for the patient to voice their mental concerns while hospitalized St. 8 Provide mental health support to patients St. 104 Be responsible for patients' overall mental well-being St. 75 Assist in patient crisis management when needed St. 93 Offer emergency support to address patients' immediate needs
	2. Specific roles and responsibilities in different hospital units	St. 98 Assist patients in their decisions over treatment, especially extraordinary treatment like fertility counseling St. 92 Provide support to families of patients diagnosed with rare conditions or terminal diseases St. 99 Assist/Support patients making life support choices St. 95 Assists mothers with childbirth issues
MHCs' specific role in the hospital setting	3. Building relationships with patients	St. 58 Be empathic in their attitude and behavior St. 30 Make the patient feel seen and heard
	4. Assessing/Evaluating patients' mental health status	St. 73 Facilitate psychological assessments and provide supportive counseling accordingly St. 44 Assess mothers to see if they are fit to be discharged and care for their baby
	5. Assisting and supporting patients with physical, psychological, and social challenges in relation to their medical condition	St. 7 Help patients understand the different steps to take in their recovery St. 10 Assist/Support patients adapting to lifelong conditions such as diabetes
	6. Educating patients	St. 14 Initiate and teach coping skills to patients St. 70 Be an educator and provide psychoeducation to patients when appropriate
Roles and responsibilities as a multidisciplinary team member	7. Advocating for patients in the multidisciplinary team	St. 67 Advocate for patients' rights St. 65 Be an informant to other health professionals on patients' needs
	8. Mediating communication among healthcare professionals, patients, and families	St. 76 Be a link between the services and the patient at the hospital St. 19 Aid in communication between doctor, patient, and family St. 71 "Put out fires"—be a mediator in cases of tension between different stakeholders (e.g., patients and health professionals)
	9. Collaborating with other multidisciplinary team members on patients' care	St. 43 Assist health professionals in informing mothers on baby care assistance options once delivered St. 28 Offer health professionals different, more up-to-date ideas for the best care for the patient St. 87 Communicate ideas on patients' needs/care to other healthcare providers as counselors are an extra set of ears to patients
	10. Training other multidisciplinary members on general wellness and mental health	St. 38 Train staff on how to be emotionally supportive to patients St. 66 Be an educator to health professionals
	11. Offering training and emotional support to other multidisciplinary team members	St. 86 Facilitate coping techniques training to staff and nursing team St. 40 Provide training to staff on their own emotional well-being St. 39 Provide emotional support to staff

Abbreviation: MHCs, mental health counselors.

mental health care in the patient's overall care within the hospital setting. Participants of the current study highlighted the need for MHCs to address patients' overall mental health and immediate/emergency/crisis needs by delivering daily individual counseling services. Although, to this day, no research has yet studied healthcare professionals' perspectives on integrating MHCs in hospital settings, there is an acknowledgment in medical healthcare that mental health is one of the main drivers of health (Happell et al., 2019). The importance of simultaneously addressing patients' overall mental health and physical needs was found in other primary care studies (Peyrot & Rubin, 2007; Pomerantz et al., 2009; Schafer et al., 2009). In a study by Schafer et al. (2009), general practitioners perceived onsite counseling services in primary care mental health settings as beneficial in their general practice. Most participants (82%) referred their patients to onsite counseling services and believed that counseling was preventive. Subsequently, through the immediate interventions of the onsite counseling, patients did not need to be referred to secondary service.

These findings further emphasized MHCs' responsibilities to cater to patients' immediate needs and assist in crisis management when needed. The need for crisis interventions and counseling services in hospitals aligns with Jacobson and Butler's (2013) identified need for family counselors in trauma units to provide crisis counseling to individuals suf-

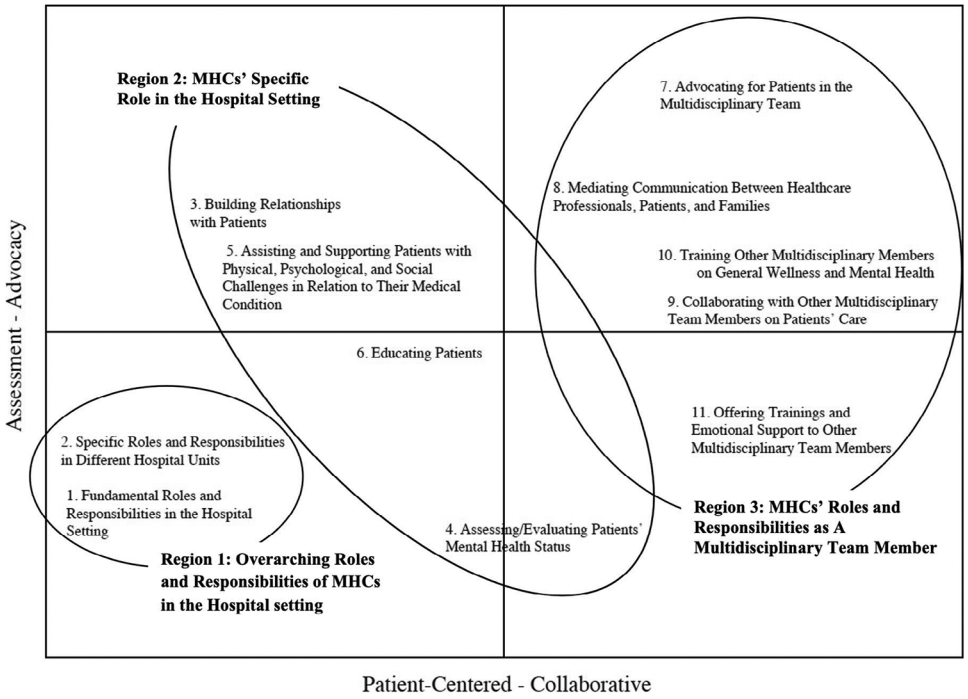

FIGURE 1 Two dimensions of the point map.

fering from traumatic brain injury. McKinlay et al. (2008) also emphasized having family counselors understand the psychological and physical effects of medical trauma in hospital settings, especially because medical trauma is one of the most pervasive public health problems and the leading cause of death among adolescents and children (U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Neurological Disorders and Stroke, 2012).

Moreover, the first region also described specific tasks of MHCs within specific units in the hospital setting where patients needed more support due to the unique challenges that come with their specific medical conditions. Healthcare professionals viewed MHCs as responsible for assisting and supporting patients with conditions such as COVID-19, cancer remission, and rare or terminal diseases and supporting long-term hospital stay patients, new mums, and mothers with childbirth issues. Researchers reported that supporting and helping patients in hospital units where patients are diagnosed with rare conditions or terminal diseases, cancer remissions, and dealing with life support choices improved patients' overall mental health and quality of life (McCombie et al., 2016; Ramnarain et al., 2021; Schoultz et al., 2015). In both McCombie et al. (2016) and Schoultz et al. (2015) studies, patients who received additional cognitive behavioral therapy compared with the standard-care treatment of inflammatory bowel disease reported more significant improvement in their depression, anxiety, and quality of life. There is also an increasing appreciation of the positive impact of psychological health on cardiovascular health with reduced cardiovascular risks (Levin et al., 2021). Similarly, as 5%–64% of patients developed PTSD or related symptoms during their recovery from critical care units, the need for counseling services within these specialized units amplified (Griffiths et al., 2007). Other studies also revealed that patients suffered significant long-term psychological disturbances during and following recovery from critical illness (Broomhead & Brett et al., 2002; Peris et al., 2011; Righy et al., 2019). Early measures for the prevention of PTSD are suggested in critical care units (Righy et al., 2019).

In the current study, fertility counseling was another specialized area where MHCs were viewed to assist patients through their diagnoses and their decisions on fertility treatment. This finding aligns with a cross-sectional online survey result from Sweden (Pestoff et al., 2016). Genetic counselors are identified as adding value in the clinical setting by being the link that closes the gap between the patient's medical and psychosocial needs (Benammar et al., 2023; Pestoff et al., 2016). Genetic counselors are described as more accessible than medical geneticist doctors, who have the primary medical responsibility. Their role is to counsel couples on their calculated risks while ensuring the sound realization of presumptions and prenatal testing procedures suited to each (Benammar et al., 2023). They are viewed as performing as case managers with a more holistic, ethical, and psychological perspective, offering continuous support and building a relationship with the patient (Pestoff et al., 2016).

According to Zhang et al. (2016), building a therapeutic relationship to create a safe space for patients to share their concerns, clarify illness perceptions, plan, and help them reframe during the counseling relationship positively improves recovery. This aligned with region 2 (*MHCs'*

Specific Roles in the Hospital Setting) in the current study results, where healthcare professionals identified unique characteristics and skills MHCs need to build therapeutic relationships with patients. They addressed the need for counselors to be empathic in their attitude and behavior, where patients were emotionally supported, seen, heard, attended, and encouraged to foster a safe environment. MHCs are trained and skilled in these identified attitudes, believing in developing a sustainable, effective therapeutic relationship as the basis for all therapeutic work (Hansen, 2013; Hardy et al., 2007; Johnson et al., 2021) and at the core of effective therapy that activates change and lasting transformation (Bland, 2013). This circumscribed view of the therapeutic relationship often distinguishes MHCs' work/services from other healthcare professionals in hospital settings who are traditionally trained via a medical model that is more disease-/cure-focused (Pestoff et al., 2016) rather than focusing on the patient as a whole (Levin et al., 2021).

Participants in the current study also identified the need for MHCs to facilitate onsite psychological assessment to identify patients going through possible psychological and emotional reactions and refer or intervene accordingly. This assessment role given to MHCs in the current results was parallel to previous reports. Hall and Hall (2013) argued that counselors must assess and identify clients' problems resulting from their medical trauma. They viewed counselors' assessment tasks as part of preventive interventions. Similarly, in Johnson et al. (2021), professional counselors identified prevention as a foundational counseling principle together with the principles of wellness and development that counselors must practice as part of the interprofessional team in hospital settings.

Thus, the first two regions complementarily highlighted MHCs' overall role grounded in wellness, prevention, and development, aligning with the American Counseling Association's (ACA's) (2010a) general definition for counseling as well as other research findings on counselors mainly operating from their professional identity (e.g., Mellin et al., 2011). On the other hand, neither the ACA's (2014) general definition nor Mellin et al.'s results specified assessment and evaluation as one of the counselors' roles. Mellin et al.'s participants viewed assessment as the central role that distinguished counselors from psychologists and social workers, where they perceived psychologists attending to patients' pathological assessments to identify the psychiatric treatment and social workers focusing on systemic issues. In contrast, counselors focused on wellness, development, and prevention. In the current study, healthcare professionals perceived MHCs to assess patients for further psychiatric treatment. This conflicting finding may mean that either healthcare professionals in the current study were not as clear about what MHCs can or cannot do or there may be new/additional tasks for MHCs as part of their unique roles within hospital settings when compared to other settings (e.g., private practice and schools).

On another note, these conflicting findings may also reflect the different theoretical and mental health cultures among different professionals within the healthcare team. Counseling is highly rooted in subjectivity and the counseling relationship. In contrast, Hansen (2013) stated that the mental health culture emphasizes descriptive diagnosis and other varieties of medicalization that suppress human subjectivity. Hansen further talks about the impact of the medical model of psychotherapy that dominated mental health culture for decades and how helping professionals were forced to assess/diagnose and use medical terminology to describe their practices due to the design of the infrastructure of managed care companies to provide reimbursement to healthcare professionals. Thus, these findings invite counseling professionals to learn new ways of navigating through the dominant medical model in hospital settings while holding to its core emphasis on subjective practice and counseling relationships.

On the other hand, *MHCs' Roles and Responsibilities as a Multidisciplinary Team Member* region presented that MHCs facilitated all patient services through holistic care. Healthcare professionals reported that MHCs were responsible for facilitating communication between patients and families and other healthcare professionals involved in the patient's care while training and supporting healthcare professionals on mental wellness. The main highlighted tasks of MHCs in this region were advocacy, mediation, and collaborative work. MHCs were reported as patients' advocates responsible for speaking on behalf of patients and being the patients' voice within the multidisciplinary team. Advocacy has a long tradition of being an essential role and task of counselors in counseling (Cade, 2023). Counselors are guided by the ACA Code of Ethics (2014) and the ACA Advocacy Competencies (Toporek & Daniels, 2018) framework to assist counselors in identifying appropriate levels of advocacy for different circumstances. As healthcare professionals must prioritize medical treatment over understanding patients' emotional, psychological, and social needs, issues, and struggles, MHCs appeared to become the communication link among patients, families, and healthcare professionals through advocacy. MHCs were reported to provide healthcare professionals with added information they might have missed and create a bridge between medical and mental health services, as the "spider-in-the-web" (Pestoff et al., 2016, p. 350) of hospital settings.

Consequently, MHCs were expected to collaborate with healthcare professionals on patient care through advocacy and communication. The need for multidisciplinary team collaboration, including MHCs highlighted in the current study, aligned with the WHO's (WHO, 2010) recognition of the need for cooperation among healthcare professionals in education and clinical practice. The WHO Framework for Action states interprofessional "collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, careers, and communities to deliver the highest quality of care. It allows health workers to engage individuals whose skills can help achieve local health goals" (WHO, 2010, p. 7). Similarly, in supporting multidisciplinary collaboration, Ghassemi (2017) further highlighted the importance of shared decision-making and interprofessional collaboration among doctors, nurses,

MHCs, and social workers as essential to support patients' treatment and recovery. Thus, our results also emphasized the place and need for MHCs as multidisciplinary team members in hospital settings.

Healthcare professionals also viewed MHCs' tasks as more comprehensive than solely patient-focused in the hospital setting. They reported seeking MHCs to train other multidisciplinary members on general wellness and mental health while offering emotional support and training for personal mental wellness. This expectation and identified need highlighted healthcare professionals' appreciation for adding emotional/psychological awareness and skills into their services and overall patient care. These findings align with literature reporting the role of counselors in providing support to nurses with stress management, strengthening their coping skills, increasing self-awareness and practice in self-care, positively impacting the overall effectiveness of their nursing care, and leading to improved patient care (Moeller, 1992; Williams et al., 2022).

Finally, the three regions and their clusters were also laid out over two dimensions, describing continuums of MHCs' patient-centered-collaborative (dimension 1) and assessment-advocacy (dimension 2) tasks. In the *Patient-Centered-Collaborative* dimension, healthcare professionals described MHCs' unique professional roles and responsibilities toward patients' mental well-being, from providing direct emotional support through counseling to indirect services through collaborating with other healthcare professionals. On the other hand, the *Assessment-Advocacy* dimension outlined a continuum of MHCs' responsibilities, from assessing patients' mental health status, needs, treatment, and follow-up care to advocating for the patients as they also mediated among different stakeholders to enhance patients' care. This latter end of the second dimension appeared to specify MHCs' role in closing the gap between medical and mental care for patients.

In conclusion, MHCs in hospital settings are rare; thus, their roles and responsibilities must still be scholarly and professionally defined. Offering a framework, our results outline how MHCs could practice as team members within the multidisciplinary team, be integrated into patients' medical care, and coordinate counseling activities in collaboration with other healthcare professionals in the hospital settings.

Limitations

The current study results must be considered within the context of its limitations. First, by targeting only professionals from one hospital, the generalizability of the results is limited to the healthcare professionals working in the specific local hospital. Nevertheless, this study can fall under naturalistic generalizability (Hays & McKibben, 2021), where readers with familiarity and similar experiences with this study's focus and context can compare their personal and professional contexts with the study's results. Second, this study only presents the healthcare professionals' perspectives on the MHCs' tasks and does not include MHCs' perspectives. The involvement of MHCs may have offered different and more comprehensive results. Third, potential variables that were not controlled in this study may have influenced the results. For example, the time participants have been exposed to the counseling services in the hospital settings, the different experiences participants have working with MHCs, and the diverse values professionals held on the importance of psychological support and physical care in the hospital setting are a few to mention. Similarly, we did not examine if the participants perceived other mental health professionals' (e.g., psychologists and clinical social workers) roles and responsibilities in the hospital in similar terms. Fourth, to promote participation, we offered incentives to participants; however, due to time restrictions and surges in COVID cases, only a limited number of participants could participate in the three rounds of data collection. Lastly, although testimonial validity procedures were diligently utilized in this study (i.e., including participants in all data collection, the research team, and an external auditor), editing and syntheses of the statements and preliminary structuring of the statements may not have been entirely free from the researchers' interpretations and/or influence of the data.

Implications of the study

The current study offers implications for MHCs', counselor training programs, counseling and healthcare professionals' practices, and future research attempts of counseling scholars. First, considering the current lack of MHCs in most hospital settings and the lack of scholarly and professionally defined roles, the results of this study inform MHCs about what healthcare professionals expect from them in a hospital setting where counseling services are available. These expectations may also inform MHCs about what healthcare professionals perceive as missing in patients' care and how MHCs' services can address these needs to enhance patients' well-being. Based on the current study results, MHCs may complement patients' medical care with psychological care by providing counseling, advocacy, collaboration, psychoeducation, and training services to patients, families, and healthcare professionals within the multidisciplinary team. They can be part of the healthcare team in each hospital unit to assess and identify patients' emotional, psychological, and social needs as they provide support, possible preventive interventions (e.g., medical trauma), and referrals as needed. For example, MHCs may identify patients' level of safety or potential harm to self and/or others by collaborating with healthcare professionals on patients' care from admission to discharge. Lastly, MHCs may also provide emotional support to healthcare professionals and training on overall mental wellness and coping techniques that will aid healthcare professionals in increasing awareness of how to attend to themselves and others emotionally. MHCs may use the results of this study and include an information session about their role in the hospital setting in their training for

healthcare professionals to better understand counselors' involvement.

Next, the tasks of MHCs in hospital settings inform both site and university supervisors (clinical supervisors) and master's and doctoral counselor training programs. Given the results of this study highlighting MHCs' tasks of providing continuous psychological care to all hospitalized patients through counseling, advocacy, collaboration, psychoeducation, and training services to patients, families, and healthcare professionals within the multidisciplinary team, ongoing clinical supervision is essential for the MHCs' growth and maintenance of counseling skills (Bernard & Goodyear, 1998). Thus, clinical supervisors can create a safe, compassionate, and empathic space for MHCs to process their experience and client work. They may consider the consistent and continuous expenditure of emotional energy MHCs spend to be emotionally present for their patients. Results identified MHCs as critical professionals who work with different team members and engage in shared decision-making. Considering the possible challenges of this task, supervisors may consider supporting and guiding MHC trainees in their collaborative and advocacy work in IBH settings for the best interest of their patients. For example, they may support MHCs in navigating through their collective work and provide a space for MHCs to consult on different options and resources available for patients within the community, as they help MHCs process client cases, treatment plans, and referrals during supervision sessions. It also helps them engage in shared decision-making as an essential tool to support patients' treatment and recovery. MHCs' services were identified within emergencies and crises. Thus, supervisors may want to be accessible to MHCs in emergencies to allow MHCs to consult on various safety measures/decisions/referrals needed for patients' safety and provide a space to consult on ethical dilemmas brought by complex life decisions patients' face.

Moreover, the results identified certain factors (e.g., psychological assessments, crisis interventions, creating a space for patients to express their concerns, process their diagnosis, implications of their medical condition, and supporting them in adapting to lifelong conditions such as diabetes) as unique considerations of practice for MHCs in the hospital setting that differ from other counseling settings. Specifically, involvement and intervention in crisis and understanding some implications of medical conditions may be critical training areas for MHCs doing their internship in IBH settings. CACREP (2023) standards require counseling programs to include disaster/crisis counseling. However, as the unique nature of the hospital setting demands MHCs to be skilled at responding to crises and work in the emergency units, counselor training programs may consider including crisis counseling courses in their curriculum imperatively. Weaving the crisis intervention content in other classes may avoid exposing students to in-depth crisis counseling training that supports MHCs in utilizing crisis intervention skills, particularly in hospital settings. Additionally, training programs preparing both master's and doctorate counseling students may train MHCs in collaborative practice and teamwork skills because they work closely with families, patients, communities, and healthcare professionals to provide the highest patient care. To train MHC trainees to navigate their professional relationships with healthcare professionals involving multiple roles, such as colleagues, educators, and counselors, programs may cultivate public speaking skills and teaching techniques as trainees may need to devise and implement workshops on mental health wellness and coping strategies for their colleagues. Ultimately, counseling programs and professionals may use the results of this study to advocate, promote, and provide awareness on the impact of MHCs as part of healthcare professional teams in different hospital units in facilitating services and enhancing patients' overall well-being. Such efforts may prompt a significant expansion in counseling and counselor training programs. Counseling professionals, specifically counselor educators and CACREP, may consider developing a concentration area on Counseling in Integrated Behavioral Health (IBH) Settings as part of counselor training programs.

This study also carries implications for healthcare professionals. Having counseling units and offices within the hospital, healthcare professionals can collaborate with onsite MHCs to identify patients needing counseling and provide holistic care addressing patients' medical and mental health needs conjointly from admission to discharge. Thus, they may collaborate with MHCs to develop counseling units within the hospital or counseling offices in different hospital units to ease the accessibility of counseling services. Similarly, healthcare professionals may utilize these results to emphasize further and report the need for and critical work of MHCs to hospital administrators and local, state, regional, and federal health services boards. The results of this study invite different healthcare professionals to consider adding interprofessional education to their training programs. All healthcare professionals may be trained on the various tasks and responsibilities of other professionals within the multidisciplinary team, particularly MHCs, and learn to communicate and collaborate effectively for a common goal: patients' overall well-being.

Finally, as the current study was a preliminary research effort on understanding MHCs' roles and responsibilities in hospital settings, researchers may consider replicating the study with expanded populations (e.g., psychiatrists and psychologists) from other hospital settings in the United States. Such efforts offer opportunities to observe potential similarities and differences across healthcare professionals as well as hospital settings. Researchers may also examine MHCs and their perspectives on their tasks, roles, and responsibilities in hospital settings to observe similarities, differences, and complementary perspectives with the current study results. With a more detailed database from those further studies, researchers may develop instruments to assess the effectiveness of MHCs and MHC-integrated programs in varying hospital settings. Finally, other research efforts may validate those instruments to establish further the evidence base for MHCs' work in hospital settings.

AUTHOR CONTRIBUTIONS

Suelle Micallef Marmara' was the principal researcher and author of this study, with a supportive contribution by Gülşah Kemer. Their order in the author byline reflects their contribution to this study and article.

CONFLICT OF INTEREST STATEMENT

The authors have no known conflicts of interest.

ORCID

Suelle Micallef Marmara' https://orcid.org/0009-0001-6397-588X
Gülşah Kemer https://orcid.org/0000-0002-6577-8636

REFERENCES

American Counseling Association. (2010a, March). *Consensus definition of counseling*. https://www.counseling.org/about-us/about-aca/20-20-a-vision-for-the-future-of-counseling/consensus-definition-of-counseling

American Counseling Association (ACA). (2014). *2014 ACA code of ethics*. https://www.counseling.org/resources/aca-code-of-ethics.pdf

Almeida, F. (2018). Strategies to perform a mixed methods study. *European Journal of Education Studies*, *5*(1), 137–151. https://doi.org/10.5281/zenodo.1406214

Kemer, G. (2020). A comparison of beginning and expert supervisors' supervision cognitions. *Counselor Education and Supervision*, *59*, 74–92. https://doi.org/10.1002/ceas.12167

Kemer, G., Borders, L. D., & Willse, J. T. (2014). Cognitions of expert supervisors in academe: A concept mapping approach. *Counselor Education and Supervision*, *53*, 2–18. https://doi.org/10.1002/j.1556-6978.2014.00045.x

Bernard, J. M., & Goodyear, R. K. (1998). *Fundamentals of clinical supervision* (2nd ed.). Allyn.

Benammar, A., Munnich, A., Poulain, M., Magnan, F., Racowsky, C., & Ayoubi, J. M. (2023). The importance of on-site genetic counseling for prospective assisted reproductive technology patients. *Journal of Assisted Reproduction and Genetics*, *40*, 1341–1347. https://doi.org/10.1007/s10815-023-02802-2

Bisson, J. I., Wright, L. A., Jones, K. A., Lewis, C., Phelps, A. J., Sijbrandij, M., Varker, T., & Roberts, N. P. (2021). Preventing the onset of post traumatic stress disorder. *Clinical Psychology Review*, *86*, 1–17. https://doi.org/10.1016/j.cpr.2021.102004

Broomhead, L. R., & Brett, S. J. (2002). Clinical review: Intensive care follow-up – What has it told us? *Critical Care*, *6*(5), 411–417.

Bedi, R. P. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology*, *53*(1), 26–35. https://psycnet.apa.org/doi/10.1037/0022-0167.53.1.26

Bland, A. M. (2013). A vision of holistic counseling: Applying humanistic, existential principles in the therapeutic relationship. *Journal of Holistic Psychology*, *2*, 277–282. https://www.millersville.edu/psychology/files/bland/blandholistic.pdf

Cade, R. (2023). Editorial perspective: Publishing as a form of advocacy in counseling. *Journal of Professional Counseling: Practice, Theory and Research*, *50*, 1–2. https://doi.org/10.1080/15566382.2023.2194201

Calley, N. G., & Hawley, L. D. (2008). The professional identity of counselor educators. *The Clinical Supervisor*, *27*(19), 3–16. https://doi.org/10.1080/07325220802221454

Council for Accreditation of Counseling and Related Educational Programs (CACREP). (2023). *2024 standards*. https://www.cacrep.org/wp-content/uploads/2023/06/2024-Standards-Combined-Version-6.27.23.pdf

Garman, A. N., Leach, D. C., & Spector, N. (2006). Worldviews in collision: Conflict and collaboration across professional lines. *Journal of Organizational Behavior*, *27*, 829–849. https://psycnet.apa.org/doi/10.1002/job.394

Ghassemi, A. E. (2017). Interprofessional collaboration between mental health counselors and nurses. *Creative Nursing*, *23*(4), 242–247. https://doi.org/10.1891/1078-4535.23.4.242

Goodyear, R. K., Tracey, T. J. G., Claiborn, C. D., Lichtenberg, J. W., & Wampold, B. E. (2005). Ideographic concept mapping in counseling psychology research: Conceptual overview, methodology, and an illustration. *Journal of Counseling Psychology*, *52*(2), 236–242. https://psycnet.apa.org/doi/10.1037/0022-0167.52.2.236

Griffiths, J., Fortune, G., Barber, V., & Young, J. (2007). The prevalence of post-traumatic stress disorder in survivors of ICU treatment: A systematic review. *Intensive Care Medicine*, *3*, 1506–1518. https://doi.org/10.1007/s00134-007-0730-z

Grimes, T. O. (2020). Exploring the phenomenon of rural school counselors' professional identity construction. *Professional School Counseling*, *24*(1), 1–13. https://doi.org/10.1177/2156759X20965180

Grover, S., Dua, D., Sahoo, S., Mehra, A., Nehra, R., & Chakrabarati, S. (2020). Why all COVID-19 hospitals should have mental health professionals: The importance of mental health in worldwide crisis! *Asian Journal of Psychiatry*, *51*, 1–7. https://doi.org/10.1016/j.ajp.2020.102147

Hall, M. F., & Hall, S. E. (2013, March). *When treatment becomes trauma: Defining, preventing, and transforming medical trauma* [Article 73]. Vista Online: American Counseling Association. https://www.counseling.org/docs/default-source/vistas/when-treatment-becomes-trauma-defining-preventing-.pdf

Hansen, J. T. (2013). *Philosophical issues in counseling and psychotherapy: Encounters with four questions about knowing, effectiveness, and truth*. Rowman & Littlefield.

Hanson, W. E., Creswell, J. W., Plano Clark, V. L., Petska, K. S., & Creswell, J. D. (2005). Mixed methods research designs in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 224–235. https://psycnet.apa.org/doi/10.1037/0022-0167.52.2.224

Hardy, G., Cahill, J., & Barkham, M. (2007). Active ingredients of the therapeutic relationship that promote client change: A research perspective. In P. Gilbert & R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 24–42). Routledge.

Haar, J., Hoes, L., Coles, C. E., Seamon, K., Fronhling, S., Jager, D., Valenza, F., Braud, F., Petris, L. D., Bergh, J., Ernberg, I., Besse, B., Barles, F., Garralda, E., Piris-Gimenez, A., Baumann, M., Apolne, G., Soria, J. C., Tabernero, J., … Voest, E. E. (2020). Caring for patients with cancer in the COVID-19 era. *Nature Medicine*, *26*, 665–671. https://doi.org/10.1038/s41591-020-0874-8

Happell, B., Platania-Phung, C., Bocking, J., Ewart, S. B., Scholz, B., & Stanton, R. (2019). Consumers at the Centre: Interprofessional solutions for meeting mental health consumers' physical health needs. *Journal of Interprofessional Care*, *33*(2), 226–234. https://doi.org/10.1080/13561820.2018.1516201

Hays, D. G., & Singh, A. A. (2023). *Qualitative research in educational and social settings* (2nd ed.). Cognella.

Hays, D. G., & McKibben, W. B. (2021). Promoting rigorous research: Generalizability and qualitative research. *Journal of Counseling & Development*, *99*, 178–188. https://doi.org/10.1002/jcad.12365

Javed, B., Sarwer, A., Soto, E. B., & Mashwani, Z. U. (2020). The coronavirus (COVID-19) pandemic's impact on mental health. *The International Journal of Health Planning and Management*, *35*(5), 993–996. https://doi.org/10.1002/hpm.3008

Jacobson, L., & Butler, S. K. (2013). Grief counseling and crisis intervention in hospital trauma units: Counseling families affected by traumatic brain injury. *The Family Journal: Counseling and Therapy for Couples and Families*, *21*(4), 417–424. https://doi.org/10.1177/1066480713488530

Johnson, K. F., Blake, J., & Ramsey, H. E. (2021). Professional counselors' experiences on interprofessional teams in hospital settings. *Journal of Counseling and Development*, *99*, 406–417. https://doi.org/10.1002/jcad.12393

Johnson, K. F., & Mahan, L. (2019). A qualitative investigation into behavioral health providers attitudes towards interprofessional clinical

collaboration. *Journal of Behavioral Health Services and Research*, *46*, 636–647. https://doi.org/10.1007/s11414-019-09661-9

Kane, M., & Trochim, W. (2007). *Concept mapping for planning and evaluation*. Sage.

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A vision for the future of counseling: The new consensus definition of counseling. *Journal of Counseling and Development*, *92*, 366–372. https://doi.org/10.1002/j.1556-6676.2014.00164.x

Klein, J. L., & Beeson, E. T. (2022). An exploration of clinical mental health counselors' attitudes toward professional identity and interprofessionalism. *Journal of Mental Health Counseling*, *44*(1), 68–81. https://www.sciencegate.app/app/redirect#aHR0cHM6Ly9keC5kb2kub3JnLzEwLjE3NzQ0L21laGMuNDQuMS4wNg==

Law Insider Dictionary. (n.d.). Medical professional definition: 219 samples. In *Law Insider Dictionary*. https://www.lawinsider.com/dictionary/medical-professional.

Levin, G. N., Cohen, B. E., Commodore-Mensah, Y., Fleury, J., Huffman, J. C., Khalid, U., Labarthe, D. R., Lavretsky, H., Michos, E. D., Spatz, E. S., & Kubzansky, L. (2021). Psychological health, well-being, and the mind-heart-body connection: A scientific statement from the American heart association. *Circulation*, *143*, e763–e783. https://doi.org/10.1161/CIR.0000000000000947

Li, C., Zhu, P., & Loveless, C. (2022). Counselors' challenging experience in integrated behavioral healthcare: A qualitative exploration. *Counselor Education and Supervision*, *62*, 80–92. https://doi.org/10.1002/ceas.12258

McCombie, A., Gearry, R., Andrews, J., Mulder, R., & Mikocka-Walus, A. (2016). Does computerized cognitive behavioral therapy help people with inflammatory bowel disease? A randomized controlled trial. *Inflammatory Bowel Disease*, *22*(1), 171–189. https://doi.org/10.1097/MIB.0000000000000567

McGough, P. M., Bauer, A. M., Collins, L., & Dugdale, D. C. (2016). Integrating behavioral health into primary care. *Population Health Management*, *19*(2), 81–87. https://doi.org/10.1089/pop.2015.0039.

McGahey, J. T., & Wallace, M. D. (2021 June 18). Counselors and the urgent care clinic: A new accessible delivery option. *Counseling Today*, https://ct.counseling.org/2021/06/counselors-and-the-urgent-care-clinic-a-newaccessible-delivery-option/#.

McKinlay, A., Grace, R. C., Horwood, L. J., Fergusson, D. M., Ridder, E. M., & MacFarlane, M. R. (2008). Prevalence of traumatic brain injury among children, adolescents and young adults: Prospective evidence from a birth cohort. *Brain Injury*, *22*, 175–181. https://doi.org/10.1080/02699050801888824

Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling and Development*, *89*(2), 140–146.

Michell, R., & Boyle, B. (2015). Professional diversity, identity salience and team innovation: The moderating role of open mindedness norms. *Journal of Organizational Behavior*, *36*, 873–894. https://psycnet.apa.org/doi/10.1002/job.2009

Moeller, K. (1992). The role of a counselor for nurses in a hospital setting. *Nursing Management*, *23*(12), 61–72. https://doi.org/10.1097/00006247-199212000-00019

Moss, J. M., Gibson, D. M., & Dollarhide, C. T. (2014). Professional identity development: A grounded theory of transformational tasks of counselors. *Journal of Counseling & Development*, *92*, 3–12.

National Center for Health Statistics. (2018). *Health, United States, 2017: With special feature on mortality*. National Center for Health Statistics. https://www.cdc.gov/nchs/data/hus/hus17.pdf

Neukrug, E. S. (2017). *A brief orientation to counseling: Professional identity, history and standards* (2nd ed.). Cengage Learning.

Pestoff, R., Ingvoldstad, C., & Skirton, H. (2016). Genetic counsellors in Sweden: Their role and added value in the clinical setting. *European Journal of Human Genetics*, *24*, 350–355. https://doi.org/10.1038/ejhg.2015.110

Peris, A., Bonizzoli, M., Iozzelli, D., Migliaccio, M. L., Zagli, G., Bacchereti, A., Debolini, M., Vannini, E., Solaro, M., Balzi, I., Bendoni, E., Bacchi, I., Giovannini, V., & Belloni, L. (2011). Early intra-intensive care unit psychological intervention promotes recovery from post traumatic stress disorders, anxiety, and depression symptoms in critically ill patients. *Critical Care*, *15*(1), R41–R41. http://ccforum.com/content/15/1/R41

Peyrot, M., & Rubin, R. (2007). Behavioral and psychosocial interventions in diabetes. *Diabetes Care*, *30*(10), 2433–2440. https://doi.org/10.2337/dc07-1222

Proven By User LLC. (2023). *Proven by user: UX testing & research tools*. Proven By User LLC.

Pomerantz, A., Corson, J. A., & Detzer, M. J. (2009). The challenge of integrated care for mental health: Leaving the 50 minute hour and other sacred things. *Journal Clinical Psychology Medical Settings*, *16*, 40–46. https://doi.org/10.1007/s10880-009-9147-x

Ramnarain, D., Aupers, E., Oudsten, B. D., Oldenbeuving, A., Vries, J. D., & Pouwels, S. (2021). Post intensive care syndrome (PICS): An overview of the definition, etiology, risk factors, and possible counseling and treatment strategies. *Expert Review of Neurotherapeutics*, *21*(10), 1159–1177. https://doi.org/10.1080/14737175.2021.1981289

Reinert, M., Fritze, D., & Nguyen, T. (2022 October). *The state of mental health in America 2023*. Mental Health America. 2023-State-of-Mental-Health-in-America-Report.pdf

Righy, C., Rosa, R. G., Da Silva, T. A., Kochhann, R., Migliavaca, C. B., Robinson, C. C., Teche, S. P., Teixirs, C., Bozza, F. A., & Falavigna, M. (2019). Prevalence of post-traumatic stress disorder symptoms in adult critical care survivors: A systematic review and meta-analysis. *Critical Care*, *23*(213), 1–3. https://doi.org/10.1186/s13054-019-2489-3

Rocha, J., & Kemer, G. (2022). What must supervisees do to promote supervision? An exploratory sequential mixed methods approach. *The Clinical Supervisor*, *41*, 70–87. https://doi.org/10.1080/07325223.2022.2045526

Rosa, R. S., & Kane, M. (2012). Quality and rigor of the concept mapping methodology: A pooled study analysis. *Evaluation and Program Planning*, *35*, 236–245. https://doiorg.proxy.lib.odu.edu/10.1016/j.evalprogplan.2011.10.00

Schafer, T., Amoateng, G., & Wrycraft, N. (2009). An exploratory study of G.P. perceptions of the impact of a primary care counselling service on their practice. *British Journal of Guidance and Counselling*, *37*(1), 1–5.

Schoultz, M., Atherton, I., & Watson, A. (2015). Mindfulness-based cognitive therapy for inflammatory bowel disease patients: Findings from an exploratory pilot randomized controlled trial. *Trials*, *16*, 379. https://doi.org/10.1186/s13063-015-0909-5

Schot, E., Tummers, L., & Noordegraaf, M. (2020). Working on working together. A systematic Review on how healthcare professionals contribute to interprofessional collaboration. *Journal of Interprofessional Care*, *34*(3), 332–342. https://doi.org/10.1080/13561820.2019.1636007

Stahl, N., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education*, *44*(1), 26–28. https://www.researchgate.net/publication/346425936

Toporek, R. L., & Daniels, J. (2018). *American Counseling Association advocacy competencies*. https://www.counseling.org/docs/default-source/competencies/aca-advocacy-competencies-may-2020.pdf?sfvrsn=85b242c_6

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Neurological Disorders and Stroke. (2012). *NINDS traumatic brain injury information page [data file]*. http://www.ninds.nih.gov/disorders/tbi/tbi.htm

Williams, S. L., VanDerWeele, L. J., Magana, E., & Abraham, S. P. (2022). The effect of counseling on intensive care unit nurses who have experienced traumatic events. *International Journal of Science and Research Methodology*, *23*(2), 167–177.

Weinert, C., & Meller, W. (2007). Medical post-traumatic stress disorder: Catching up with the cutting edge in stress research. *Critical Care*, *11*(1), 118. https://doi.org/10.1186/cc5697

World Health Organization (WHO). (2010). *Framework for action on interprofessional education and collaborative practice*. World Health Organization. http://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf?sequence=1

World Health Organization (WHO). (2013). *Transforming and scaling up health professionals' education and training: World Health Organization Guidelines 2013*. National Library of Medicine: National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books/NBK298950/#top

Zhang, M., Hong, L., Zhang, T., Lin, Y., Zheng, S., Zhou, X., Fan, R., Wang, Z., Zhang, C., & Zhong, J. (2016). Illness perceptions and stress: Mediators between disease severity and psychological well-being and quality of life among patients with Crohn's disease. *Patient Preference and Adherence*, *10*, 2387–2396. https://www.dovepresis.com/getfile.php?fileID=33726

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